



Omaha Public Power District

444 South 16th Street Mall

Omaha, NE 68102-2247

10 CFR 50.73

LIC-14-0046

May 14, 2014

U.S. Nuclear Regulatory Commission

Attn: Document Control Desk

Washington, DC 20555-0001

Fort Calhoun Station, Unit No. 1

Renewed Facility Operating License No. DPR-40

NRC Docket No. 50-285

Subject: Licensee Event Report 2014-003, Revision 0, for the Fort Calhoun Station

Please find attached Licensee Event Report 2014-003, Revision 0. This report is being submitted pursuant to 10 CFR 50.73(a)(2)(iv)(A), Specified System Actuation (RPS). There are no new commitments being made in this letter.

If you should have any questions, please contact Terrence W. Simpkin, Manager, Site Regulatory Assurance, at (402) 533-6263.

Sincerely,


Louis P. Cortopassi

Site Vice President and CNO

LPC/epm

Attachment

c: M. L. Dapas, NRC Regional Administrator, Region IV
J. M. Sebrosky, NRC Senior Project Manager
J. C. Kirkland, NRC Senior Resident Inspector

NRC FORM 366 (02-2014)		U.S. NUCLEAR REGULATORY COMMISSION		APPROVED BY OMB: NO. 3150-0104		EXPIRES: 01/31/2017								
 LICENSEE EVENT REPORT (LER) (See Page 2 for required number of digits/characters for each block)				Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA, Privacy and Information Collections Branch (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to Infocollections.Resource@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.										
1. FACILITY NAME Fort Calhoun Station				2. DOCKET NUMBER 05000285		3. PAGE 1 OF 3								
4. TITLE Reactor Trip Due to Stator Water Cooling Leak During Maintenance														
5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED					
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER				
3	17	2014	2014	003	-	5	14	2014	FACILITY NAME	DOCKET NUMBER				
									05000					
									05000					
9. OPERATING MODE			11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)											
1			<input type="checkbox"/> 20.2201(b)			<input type="checkbox"/> 20.2203(a)(3)(i)			<input type="checkbox"/> 50.73(a)(2)(i)(C)			<input type="checkbox"/> 50.73(a)(2)(vii)		
			<input type="checkbox"/> 20.2201(d)			<input type="checkbox"/> 20.2203(a)(3)(ii)			<input type="checkbox"/> 50.73(a)(2)(ii)(A)			<input type="checkbox"/> 50.73(a)(2)(viii)(A)		
			<input type="checkbox"/> 20.2203(a)(1)			<input type="checkbox"/> 20.2203(a)(4)			<input type="checkbox"/> 50.73(a)(2)(ii)(B)			<input type="checkbox"/> 50.73(a)(2)(viii)(B)		
			<input type="checkbox"/> 20.2203(a)(2)(i)			<input type="checkbox"/> 50.36(c)(1)(i)(A)			<input type="checkbox"/> 50.73(a)(2)(iii)			<input type="checkbox"/> 50.73(a)(2)(ix)(A)		
100			<input type="checkbox"/> 20.2203(a)(2)(ii)			<input type="checkbox"/> 50.36(c)(1)(ii)(A)			<input checked="" type="checkbox"/> 50.73(a)(2)(iv)(A)			<input type="checkbox"/> 50.73(a)(2)(x)		
			<input type="checkbox"/> 20.2203(a)(2)(iii)			<input type="checkbox"/> 50.36(c)(2)			<input type="checkbox"/> 50.73(a)(2)(v)(A)			<input type="checkbox"/> 73.71(a)(4)		
			<input type="checkbox"/> 20.2203(a)(2)(iv)			<input type="checkbox"/> 50.46(a)(3)(ii)			<input type="checkbox"/> 50.73(a)(2)(v)(B)			<input type="checkbox"/> 73.71(a)(5)		
			<input type="checkbox"/> 20.2203(a)(2)(v)			<input type="checkbox"/> 50.73(a)(2)(i)(A)			<input type="checkbox"/> 50.73(a)(2)(v)(C)			<input type="checkbox"/> OTHER		
			<input type="checkbox"/> 20.2203(a)(2)(vi)			<input type="checkbox"/> 50.73(a)(2)(i)(B)			<input type="checkbox"/> 50.73(a)(2)(v)(D)			Specify in Abstract below or in NRC Form 366A		
12. LICENSEE CONTACT FOR THIS LER														
LICENSEE CONTACT Erick Matzke									TELEPHONE NUMBER (Include Area Code) 402-533-6855					
13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT														
CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX					
14. SUPPLEMENTAL REPORT EXPECTED						15. EXPECTED SUBMISSION DATE			MONTH	DAY	YEAR			
<input type="checkbox"/> YES (If yes, complete 15. EXPECTED SUBMISSION DATE) <input checked="" type="checkbox"/> NO														
ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)														
<p>On March 17, 2014, at 12:02 Central Daylight Time (CDT), a turbine trip and subsequent reactor trip occurred while operating at nominal 100 percent power. Maintenance was in progress on the main generator stator cooling system when system inventory was lost resulting in an automatic turbine trip due to low system pressure. Immediate response by operations personnel included implementing procedure emergency operating procedure (EOP) -00, Standard Post Trip Actions, and subsequent entry into procedure EOP-01, Reactor Trip Recovery. Based on plant system response this is considered an uncomplicated trip.</p> <p>The station determined that the root cause of the plant trip was that operational risk was not effectively identified or mitigated by individuals throughout the organization.</p> <p>The leak was isolated shortly after the trip by fully removing the probe and closing the isolation valve. Fort Calhoun Station will be implementing the Exelon risk management procedure, WC-AA-104, Integrated Risk Management. This procedure provides direction consistent with industry best practices, and requires individual review of each category of risk identification and mitigation.</p>														

**LICENSEE EVENT REPORT (LER)
CONTINUATION SHEET**

Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA, Privacy and Information Collections Branch (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to Infocollects.Resource@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

1. FACILITY NAME	2. DOCKET	6. LER NUMBER			3. PAGE
Fort Calhoun Station	05000285	YEAR	SEQUENTIAL NUMBER	REV NO.	2 OF 3
		2014	- 003	- 00	

NARRATIVE**BACKGROUND**

Fort Calhoun Station (FCS) is a two-loop reactor coolant system of Combustion Engineering design.

EVENT DESCRIPTION

On March 17, 2014, at 12:02 Central Daylight Time (CDT), a turbine trip and subsequent reactor trip occurred while operating at nominal 100 percent power. Maintenance was in progress on the main generator stator water cooling system when system inventory was lost resulting in an automatic turbine trip due to low system pressure. Immediate response by operations personnel included implementing procedure EOP-00, Standard Post Trip Actions, and subsequent entry into procedure EOP-01, Reactor Trip Recovery. Based on plant system response this is considered an uncomplicated trip.

The loss of stator water cooling system inventory occurred during the removal of generator stator water cooling conductivity electrode number CE-5043-1 for calibration. The installed safety knob did not prevent the probe from being removed from the system causing a stator water cooling leak. The technicians were unable to isolate the leak in time to prevent a turbine trip. The leak was isolated shortly after the trip by fully removing the probe and closing the isolation valve.

At 1455 Central Daylight Time (CDT), the Headquarter Operations Officer (HOO) was informed of the event per 10 CFR 50.72(b)(2)(iv)(B) (RPS Actuation) and 50.72(b)(3)(iv)(A) (Specified System Actuation (RPS)). This report is being submitted pursuant to 10 CFR 50.73(a)(2)(iv)(A), Specified System Actuation (RPS).

CONCLUSION

Fort Calhoun Station's (FCS's) risk management processes and individual behaviors/mindsets were investigated to determine the root and contributing causes of this event. The RCA team reviewed FCS procedures, standards, and expectations regarding operational risk assessment. Interviews were then conducted to determine if individual behaviors/mindsets and station culture was in line with established expectations.

The investigation concluded that there were shortfalls in individuals' mindsets and in the level of detail in the Station's risk management procedures. Mindsets and accountability contributed to the cause of this event, and current Station procedures and guidelines are not sufficiently detailed to ensure workers are not in a knowledge based performance mode when assessing risk just prior to job execution. Individual behaviors, mindset, and knowledge levels, as well as Station procedures and processes need to be at a level to ensure risk identification and mitigation actions are adequately evaluated prior to the job scheduled start time.

The Station determined that the root cause of the plant trip was that operational risk was not effectively identified or mitigated by individuals throughout the organization.

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Fort Calhoun Station	05000285	2014	- 003	- 00	3 OF 3

NARRATIVE**CORRECTIVE ACTIONS**

The leak was isolated shortly after the trip by fully removing the probe and closing the isolation valve.

Long Term Corrective Actions

To correct the root cause Fort Calhoun Station will be implementing the Exelon risk management procedure, WC-AA-104, Integrated Risk Management. This procedure provides direction consistent with industry best practices, and requires individual review of each category of risk identification and mitigation.

SAFETY SIGNIFICANCE

The loss of stator water cooling pressure caused a turbine trip to protect the main generator as designed. Plant safety systems shutdown the reactor plant and support systems operated as designed. One non-safety bus was wetted and then deenergized as a precautionary measure. No equipment was damaged. The plant trip is considered uncomplicated.

SAFETY SYSTEM FUNCTIONAL FAILURE

This does not represent a safety system functional failure in accordance with NEI 99-02, revision 7.

PREVIOUS EVENTS

None.